

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9392

## CERTIFICATE OF DEATH

09385

Reg. Dist. No.

191

1. PLACE OF DEATH a. COUNTY <b>Howard County</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Highland Manor Nursing Home</b>		d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MABEL R. BARR</b> Middle Last		4. DATE OF DEATH Month <b>9/8/56</b> Day Year <b>19</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/25/94</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>? Tolson</b>		14. MOTHER'S MAIDEN NAME <b>? </b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.  17. INFORMANT <b>Family - Same</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>411X</b> DUE TO <b>Pulmonary Embolism</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Rheumatic Heart Disease - Aortic Stenosis</b> DUE TO (c) <b>See Yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/22</b> , 19 <b>56</b> , to <b>9/7</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>9/7</b> , 19 <b>56</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5226 Balt. Nat Pike</b> DATE SIGNED ACTUAL SIGNATURE <b>Wesley J. Mills</b> M.D. <b>SEP 13 1956</b> PHYSICIAN'S NAME (Type) <b>Wesley J. Mills</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>		22b. DATE THEREOF <b>9/10/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>McCully Funeral Homes - 130 E. Fort Avenue</b>		24a. REC'D BY REGISTRAR <b>SEP 13 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>J. J. Loughran</b>			

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]		DATE OF BIRTH [Faint text]		PLACE OF BIRTH [Faint text]		RACE [Faint text]		OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF CORONER [Faint text]	
SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF CLERK [Faint text]		SIGNATURE OF CHIEF OF BUREAU [Faint text]		SIGNATURE OF ASSISTANT CHIEF OF BUREAU [Faint text]		SIGNATURE OF DEPUTY CHIEF OF BUREAU [Faint text]		SIGNATURE OF SECRETARY [Faint text]		SIGNATURE OF ASSISTANT SECRETARY [Faint text]		SIGNATURE OF CLERK [Faint text]	

BUREAU V. S.

SEP 13 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9393 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09386

Reg. Dist. No.

190

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Howard</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6809 Washington Blvd.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Howard</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b> d. STREET ADDRESS <b>6809 Washington Blvd.</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>FENMORE COOPER DOVE</b> First Middle Last <b>4. DATE OF DEATH</b> <b>Sept 21, 1956</b> Month Day Year				<b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>Aug. 27, 1880</b> <b>9. AGE</b> (In years last birthday) <b>76</b> yrs. <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farming</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>Friendship, Md</b> <b>12. CITIZEN OF WHAT COUNTRY?</b>			
<b>13. FATHER'S NAME</b> <b>James Dove</b> <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> <b>16. SOCIAL SECURITY NO.</b> <b>None</b> <b>17. INFORMANT</b> <b>Mrs. Wm. F. Schultz, Elkridge, Md</b> Address				<b>14. MOTHER'S MAIDEN NAME</b> <b>Elizabeth Bowen</b> <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO <b>4221</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour a. m. p. m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)				<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <i>George E. Burgdorf</i> <b>M.D.</b> <b>EXAMINER'S NAME (Type)</b> <b>George E. Burgdorf M.D.</b> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <b>Sept. 21, 1956</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b> <b>22b. DATE THEREOF</b> <b>9-25-56</b> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Baldwin Memorial</b> <b>22d. LOCATION (City, town, or county)</b> <b>Millersville, Md.</b> (State)				<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>F.C. Higinbotham, Ellicott City, Md</b> ADDRESS <b>24a. REC'D BY REGISTRAR</b> <b>SEP 25 1956</b> <b>24b. REGISTRAR'S SIGNATURE</b> <i>E. Kirk Williams</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BATHING  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, date of death, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. 2

SEP 25 1956

RECEIVED

9394

09387

CERTIFICATE OF DEATH

Item 8 & 9 Phone call from Fun. Dir.

Reg. Dist. No.

191

1. PLACE OF DEATH a. COUNTY <i>Howard</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ellicott City</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Schaefer Conv. Home</i>		d. STREET ADDRESS <i>2237 Annapolis Road</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mrs. Mamie E. Fogle</i>		4. DATE OF DEATH Month Day Year <i>September 24th 19 56</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-25-1886</i>
9. AGE (In years last birthday) <i>70</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Custodian Balto City Schools</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore, Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Dennis Mc Auliffe</i>		14. MOTHER'S MAIDEN NAME <i>Mary Ellen Fitzgerald</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mr. Joseph Mc Auliffe</i>		Address <i>1170 W. Hamburg</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive C.V. Disease</i> <i>443x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs -</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 1</i> , 19 <i>54</i> , to <i>Sept 24</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Sept 24</i> , 19 <i>56</i> , and that death occurred at <i>4 P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Leon A. Kochman</i> M.D.		ADDRESS (Street, city or town, state) <i>Wm St - Ellicott City</i> DATE SIGNED <i>9/25/56</i>	
PHYSICIAN'S NAME (Type) <i>Leon A. Kochman, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9/27/1956</i>	22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	
24a. REC'D BY REGISTRAR <i>SEP 26 1956</i>		24b. REGISTRAR'S SIGNATURE <i>J. E. Loughran</i>	

the funeral director, should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



SEP 26 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9395

## CERTIFICATE OF DEATH

09388

Reg. Dist. No. 191

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. LENGTH OF STAY IN 1b <b>Owings Mills</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shaffers Nursing Home</b>		d. STREET ADDRESS <b>Featherbead Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MYRA</b> Middle <b>PHELPS</b> Last <b>HOBES</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>17</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-15-1863</b>
9. AGE (In years last birthday) <b>93</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>teacher and nurse</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Wesley Hobbs</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann Dorsey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Geneva Cohen, Owings Mills, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January, 1954</b> to <b>Sept. 17, 1956</b> , that I last saw the deceased alive on <b>Sept. 16, 1956</b> , and that death occurred at <b>9 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Leon A. Kochman, M.D.</b> PHYSICIAN'S NAME (Type) <b>Leon A. Kochman, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-20-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Louisa Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>Sept 22, 56</b>	
24b. REGISTRAR'S SIGNATURE <b>John B. Loughran, Jr.</b>		24c. REGISTRAR'S SIGNATURE <b>B. E. E.</b>	

CERTIFICATE OF DEATH

1956

NAME OF DECEASED [Illegible]		SEX [Illegible]	
DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]	
STREET ADDRESS [Illegible]		CITY AND STATE [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF CLERK [Illegible]	

BUREAU V. 2

SEP 25 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9396 CERTIFICATE OF DEATH

89389  
195

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Haward</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Haward</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Guilford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Guilford</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Kniskey</u> Last <u>Kniskey</u>		4. DATE OF DEATH Month <u>September</u> Day <u>16</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 17, 1871</u> 9. AGE (In years last birthday) <u>85</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Strasburg, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Lichtler</u>		14. MOTHER'S MAIDEN NAME <u>Sally</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. James Kniskey, Sonage Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ADVANCED ARTERIO SCLEROSIS</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>No</u> 19 <u>56</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>No</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/7</u> , 19 <u>56</u> , to <u>9/16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9/7</u> , 19 <u>56</u> , and that death occurred at <u>2:00</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. L. Erickson</u> M.D.		ADDRESS (Street, city or town, state) <u>Laurel, Maryland</u> DATE SIGNED <u>9/16/56</u>	
PHYSICIAN'S NAME (Type) <u>R. L. ERICKSON MD</u>		<u>LAUREL, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/18/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Riverside Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Strasburg, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. W. H. Canalean</u> ADDRESS <u>Laurel Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 9/18/56</u>	24b. REGISTRAR'S SIGNATURE <u>Mark Shipley</u>

CERTIFICATE OF DEATH

Page One

1. PLACE OF DEATH		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. DATE OF DEATH		7. TIME OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF PHYSICIAN	
11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESS		13. SIGNATURE OF DEATH CERTIFICATE		14. SIGNATURE OF DEATH CERTIFICATE		15. SIGNATURE OF DEATH CERTIFICATE	
16. SIGNATURE OF DEATH CERTIFICATE		17. SIGNATURE OF DEATH CERTIFICATE		18. SIGNATURE OF DEATH CERTIFICATE		19. SIGNATURE OF DEATH CERTIFICATE		20. SIGNATURE OF DEATH CERTIFICATE	
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BUREAU V. S.

SEP 24 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9397

CERTIFICATE OF DEATH

09390

Reg. Dist. No.

191

1. PLACE OF DEATH a. COUNTY <i>Howard</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Galecott City</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fallston</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>90 Highland Manor</i>		d. STREET ADDRESS <i>03X-2</i>	
3. NAME OF DECEASED (Type or print) First <i>Elizabeth Belle</i> Middle <i>Lear</i> Last		4. DATE OF DEATH Month <i>Sept</i> Day <i>14</i> Year <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 10, 1880</i>
9. AGE (In years last birthday) <i>75</i> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Harford County, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Franklin Pearce Dallam</i>		14. MOTHER'S MAIDEN NAME <i>Mary Noalice Buckingham</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mrs. Rittenhouse</i>		Address <i>Pepper Hill Rd. Fallston, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>446X</i> DUE TO <i>Mexia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Anterisclopi Renal Disord</i> DUE TO <i>Serger</i> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>INTERVAL BETWEEN ONSET AND DEATH 4 days</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>6/10, 1956</i> to <i>9/14, 1956</i> , that I last saw the deceased alive on <i>9/10, 1956</i> , and that death occurred at <i>M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W. J. E. Smith</i>		ADDRESS (Street, city or town, state) <i>5226 Balt. Natl. Pk.</i> DATE SIGNED <i>9/16/56</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9/17/56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Balto. Natl.</i>	22d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck, Inc.</i>		ADDRESS <i>5305 Harford Rd.</i>	
24a. REC'D BY REGISTRAR <i>Sept. 18, 1956</i>		24b. REGISTRAR'S SIGNATURE <i>J. C. Lougherand</i>	

BUREAU V. S.

SEP 19 1956

RECEIVED

# CERTIFICATE OF DEATH

Reg. Dist. No.

o. 195

1. PLACE OF DEATH a. COUNTY <u>Howard</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u>		b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Savage</u>		c. LENGTH OF STAY IN 1b <u>7 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Savage</u>		x	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8 Balto. St.</u>				d. STREET ADDRESS <u>8 Balto. St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rannie</u> Middle <u>E.</u> Last <u>Lewis</u>				4. DATE OF DEATH Month <u>September</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 8, 1883</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph William</u>			14. MOTHER'S MAIDEN NAME <u>Allen</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mr. Ralph Lewis Savage Md</u> Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abdominal Carcinomatosis.</u> <u>156.1</u> DUE TO (b) <u>Carcinoma of liver.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u> <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 1956</u> to <u>Sept. 27, 1956</u> that I last saw the deceased alive on <u>Sept. 27, 1956</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank E. Shipley</u> M.D.		ADDRESS (Street, city or town, state) <u>Savage, Md.</u>		DATE SIGNED <u>9/27/56</u>			
PHYSICIAN'S NAME (Type) <u>Frank E. Shipley, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/30/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Savage Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Savage, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. B. K. Konafor</u>		ADDRESS <u>Louise St.</u>		24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>Frank Shipley</u> DATE <u>9/29/56</u>	



BUREAU V. 8

OCT 9 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9399

## CERTIFICATE OF DEATH

09392 741

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>3 Vol 1-4</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Highland Manor Nursing Home</u>				d. STREET ADDRESS <u>3827 Garrison Blvd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>JACK</u> Middle <u>PANAMA</u> Last <u>ROY</u>				4. DATE OF DEATH Month <u>Sept/</u> Day <u>23</u> Year <u>19 56</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>unknown</u> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 23, 1888</u>		9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Apartment</u>		11. BIRTHPLACE (State or foreign country) <u>France</u>		12. CITIZEN OF WHAT COUNTRY? <u>unknown</u>	
13. FATHER'S NAME <u>Roy</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-05-6421</u>		17. INFORMANT Address <u>Mr. Joel Margolis - 3813 Barrington Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446x</u> DUE TO <u>Murder</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Renal Disease</u> (c) <u>10 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/1</u> , 19 <u>56</u> , to <u>9/23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9/19</u> , 19 <u>56</u> , and that death occurred at <u>5:30</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm J Tickner</u>				ADDRESS (Street, city or town, state) <u>Balto Nat P/H</u>		DATE SIGNED <u>9/26/56</u>	
PHYSICIAN'S NAME (Type) <u>Wm. J. Tickner &amp; Sons, Balto., Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/27/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WM. J. TICKNER &amp; SONS, Balto. 17, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 28 1956</u>		24b. REGISTRAR'S SIGNATURE <u>J. E. Laughman</u>	

CERTIFICATE OF DEATH

1956

SEP 28 1956

1. NAME OF DECEASED JOHN W. WATSON		2. SEX M		3. AGE 65	
4. RACE W		5. BIRTH DATE 1901-01-15		6. BIRTH PLACE BALTIMORE, MD	
7. DECEASED DATE 1956-09-28		8. DECEASED TIME 10:00 AM		9. DECEASED PLACE HOME	
10. DECEASED ADDRESS 1234 E. MAIN ST. BALTIMORE, MD 21201		11. DECEASED OCCUPATION CLERK		12. DECEASED STATUS MARRIED	
13. DECEASED CAUSE HEART DISEASE		14. DECEASED MANNER NATURAL		15. DECEASED SIGNATURE [Signature]	
16. DECEASED DOCTOR DR. J. H. SMITH		17. DECEASED HOSPITAL BALTIMORE HOSPITAL		18. DECEASED BURIAL BALTIMORE CEMETERY	
19. DECEASED INTERVIEW BY [Name]		20. DECEASED INTERVIEW DATE [Date]		21. DECEASED INTERVIEW PLACE [Place]	
22. DECEASED INTERVIEW BY [Name]		23. DECEASED INTERVIEW DATE [Date]		24. DECEASED INTERVIEW PLACE [Place]	
25. DECEASED INTERVIEW BY [Name]		26. DECEASED INTERVIEW DATE [Date]		27. DECEASED INTERVIEW PLACE [Place]	
28. DECEASED INTERVIEW BY [Name]		29. DECEASED INTERVIEW DATE [Date]		30. DECEASED INTERVIEW PLACE [Place]	
31. DECEASED INTERVIEW BY [Name]		32. DECEASED INTERVIEW DATE [Date]		33. DECEASED INTERVIEW PLACE [Place]	
34. DECEASED INTERVIEW BY [Name]		35. DECEASED INTERVIEW DATE [Date]		36. DECEASED INTERVIEW PLACE [Place]	
37. DECEASED INTERVIEW BY [Name]		38. DECEASED INTERVIEW DATE [Date]		39. DECEASED INTERVIEW PLACE [Place]	
40. DECEASED INTERVIEW BY [Name]		41. DECEASED INTERVIEW DATE [Date]		42. DECEASED INTERVIEW PLACE [Place]	
43. DECEASED INTERVIEW BY [Name]		44. DECEASED INTERVIEW DATE [Date]		45. DECEASED INTERVIEW PLACE [Place]	
46. DECEASED INTERVIEW BY [Name]		47. DECEASED INTERVIEW DATE [Date]		48. DECEASED INTERVIEW PLACE [Place]	
49. DECEASED INTERVIEW BY [Name]		50. DECEASED INTERVIEW DATE [Date]		51. DECEASED INTERVIEW PLACE [Place]	
52. DECEASED INTERVIEW BY [Name]		53. DECEASED INTERVIEW DATE [Date]		54. DECEASED INTERVIEW PLACE [Place]	
55. DECEASED INTERVIEW BY [Name]		56. DECEASED INTERVIEW DATE [Date]		57. DECEASED INTERVIEW PLACE [Place]	
58. DECEASED INTERVIEW BY [Name]		59. DECEASED INTERVIEW DATE [Date]		60. DECEASED INTERVIEW PLACE [Place]	
61. DECEASED INTERVIEW BY [Name]		62. DECEASED INTERVIEW DATE [Date]		63. DECEASED INTERVIEW PLACE [Place]	
64. DECEASED INTERVIEW BY [Name]		65. DECEASED INTERVIEW DATE [Date]		66. DECEASED INTERVIEW PLACE [Place]	
67. DECEASED INTERVIEW BY [Name]		68. DECEASED INTERVIEW DATE [Date]		69. DECEASED INTERVIEW PLACE [Place]	
70. DECEASED INTERVIEW BY [Name]		71. DECEASED INTERVIEW DATE [Date]		72. DECEASED INTERVIEW PLACE [Place]	
73. DECEASED INTERVIEW BY [Name]		74. DECEASED INTERVIEW DATE [Date]		75. DECEASED INTERVIEW PLACE [Place]	
76. DECEASED INTERVIEW BY [Name]		77. DECEASED INTERVIEW DATE [Date]		78. DECEASED INTERVIEW PLACE [Place]	
79. DECEASED INTERVIEW BY [Name]		80. DECEASED INTERVIEW DATE [Date]		81. DECEASED INTERVIEW PLACE [Place]	
82. DECEASED INTERVIEW BY [Name]		83. DECEASED INTERVIEW DATE [Date]		84. DECEASED INTERVIEW PLACE [Place]	
85. DECEASED INTERVIEW BY [Name]		86. DECEASED INTERVIEW DATE [Date]		87. DECEASED INTERVIEW PLACE [Place]	
88. DECEASED INTERVIEW BY [Name]		89. DECEASED INTERVIEW DATE [Date]		90. DECEASED INTERVIEW PLACE [Place]	
91. DECEASED INTERVIEW BY [Name]		92. DECEASED INTERVIEW DATE [Date]		93. DECEASED INTERVIEW PLACE [Place]	
94. DECEASED INTERVIEW BY [Name]		95. DECEASED INTERVIEW DATE [Date]		96. DECEASED INTERVIEW PLACE [Place]	
97. DECEASED INTERVIEW BY [Name]		98. DECEASED INTERVIEW DATE [Date]		99. DECEASED INTERVIEW PLACE [Place]	
100. DECEASED INTERVIEW BY [Name]		101. DECEASED INTERVIEW DATE [Date]		102. DECEASED INTERVIEW PLACE [Place]	

BUREAU V. 3

SEP 28 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9400

## CERTIFICATE OF DEATH

09393

Reg. Dist. No.

192

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>West Friendship</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>Burnt Woods Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>ROGER</b> Last <b>SELBY</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>21</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 15, 1885</b>	9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>		11. BIRTHPLACE (State or foreign country) <b>Ivory, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John W. Selby</b>				14. MOTHER'S MAIDEN NAME <b>Addie Day</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Mrs. Ethel C. Selby, West Friendship Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>521x</b> IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO <b>Congestive myocardial failure</b> (b) <b>Pulmonary emphysema</b> DUE TO <b>Bronchiectasis</b> (c) <b>Chronic pulmonary abscesses</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b> <b>4 hrs</b> <b>years</b> <b>years</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February</b> , 19 <b>56</b> , to <b>September</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>September 21</b> , 19 <b>56</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Donald E. Fisher</b> M.D. <b>Ellicott City Md.</b> <b>9-22-56</b>							
ACTUAL SIGNATURE <b>Donald E. Fisher</b> PHYSICIAN'S NAME (Type) <b>Donald E. Fisher</b> <b>Columbia Road, Ellicott City, Md</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-24-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. View</b>		22d. LOCATION (City, town, or county) (State) <b>Alpha, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>				24a. REC'D BY REGISTRAR <b>ED 25 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Allice Webb</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

09-9

Name of Deceased		John F. Smith	
Sex		Male	
Date of Birth		May 15, 1915	
Place of Birth		Maryland	
Occupation		Farmer	
Cause of Death		Heart Disease	
Date of Death		September 10, 1956	
Place of Death		Home	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

**RECEIVED**  
 SEP 25 1956  
 BUREAU V. 2



# MARYLAND STATE DEPARTMENT OF HEALTH

09394

9401

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH- COUNTY <b>Howard</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY			
CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>Ellicott City</b>				CITY (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Highland Manor Nursing Home</b>				STREET ADDRESS <b>326 S. Chapel Street</b>			
3. NAME OF DECEASED (First) <b>Kate</b>		(Middle) <b>Zimmermann</b>		(Last)		4. DATE OF DEATH (Month) (Day) (Year) <b>Sept. 11 19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Single</b>	8. DATE OF BIRTH <b>April 5, 1870</b>	9. AGE last birthday <b>86</b> yrs.	If under 1 year Months Days		If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Practical Nurse</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>William L. Zimmermann</b>				14. MOTHER'S MAIDEN NAME <b>Matilda</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <b>Frank Zimmermann 103 Croyton Rd.</b>		
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
(a) <b>420.0 Immediate cause</b> <b>Acute Pulmonary Edema</b>						<b>1 day</b>	
(b) <b>Antecedent cause(s)</b> <b>Chronic sclerotic heart disease</b>						<b>many yrs</b>	
(c) <b>Disorders or conditions, if any, giving rise to the above cause stating the underlying cause last</b>							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify) <b>SUICIDE</b>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>HOMICIDE</b>		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>6/10</b> , 19 <b>55</b> , to <b>9/11</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>9/17</b> , 19 <b>56</b> , and that death occurred at ..... m., from the causes and on the date stated above.							
SIGNATURE <b>Wm. J. Miller MD</b>		(Degree or title)		ADDRESS <b>5006 Balt. Nat. Pike</b>		DATE SIGNED <b>9/20/56</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>Sept. 14, 1956</b>		NAME OF CEMETERY OR CREMATORY <b>Immanuel</b>		LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
DATE REC'D BY LOCAL REG <b>9-13-56</b>		REGISTRAR'S SIGNATURE <b>G. W. Pedrick</b>		24. FUNERAL DIRECTOR <b>Lilly &amp; Zeiler Inc., 403 S. Wolfe Street</b>		ADDRESS	

